REFERENCE TITLE: health and welfare; budget reconciliation

State of Arizona
House of Representatives
Forty-eighth Legislature
First Regular Session
2007

# HB 2789

Introduced by
Representative Boone (with permission of committee on Rules)

AN ACT

CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARIZONA REVISED STATUTES, TO "ACCOUNTABLE HEALTH PLANS"; CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARTICLE 2, ARIZONA REVISED STATUTES, TO "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS"; AMENDING SECTIONS 20-2341, 36-2901.03, 36-2903.01, 36-2912.01, 36-2930, 36-3410, 38-654 AND 46-803, ARIZONA REVISED STATUTES; MAKING AN APPROPRIATION; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Heading change

The chapter heading of title 20, chapter 13, Arizona Revised Statutes, is changed from "SPECIAL HEALTH INSURANCE PLANS" to "ACCOUNTABLE HEALTH PLANS".

Sec. 2. Heading change

The article heading of title 20, chapter 13, article 2, Arizona Revised Statutes, is changed from "SMALL BUSINESS HEALTH INSURANCE PLANS" to "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS".

Sec. 3. Section 20-2341, Arizona Revised Statutes, is amended to read:

20-2341. Uninsured small business health insurance plans; mandatory coverage exemption; definitions

A. A policy, subscription contract, contract, plan or evidence of coverage issued to ~~a~~ AN UNINSURED small business by a health care insurer is not subject to the requirements of any of the following:

1. Section 20-461, subsection A, paragraph 17 and subsection B.
2. Section 20-826, subsection C, paragraph 1.
3. Section 20-826, subsections F, J, K, U, V, W, X and Y.
4. Sections 20-841, 20-841.01, 20-841.02, 20-841.03, 20-841.04, 20-841.06, 20-841.07 and 20-841.08.
5. Section 20-841.05, subsections B and E.
6. Section 20-1057, subsections C, K, L, Y, Z, AA and BB.
7. Sections 20-1057.01, 20-1057.03, 20-1057.04, 20-1057.05 and 20-1057.08.
8. Section 20-1057.02, Subsection B.
9. Section 20-1342, subsection A, paragraph 8, subdivision (a).
10. Section 20-1342, subsection A, paragraphs 11 and 12.
11. Section 20-1342, subsections H, I, J and K.
12. Section 20-1342.01.
13. Sections 20-1376, 20-1376.01, 20-1376.02, 20-1376.03 and 20-1376.04.
14. Section 20-1402, subsection A, paragraph 4, subdivision (a).
15. Section 20-1402, subsection A, paragraphs 7 and 8.
16. Section 20-1402, subsections H, I, J, K and L.
17. Section 20-1404, subsection F, paragraph 1.
18. Section 20-1404, subsections I, Q, R, S, T and U.
19. Section 20-1406.
20. Sections 20-1406.01, 20-1406.02, 20-1406.03 and 20-1406.04.
21. Section 20-1407.
22. Section 20-2321.
23. Section 20-2327.
24. Section 20-2329.

B. Section 20-2304, subsection B does not apply to a policy, subscription contract, contract, plan or evidence of coverage issued to ~~a~~ AN UNINSURED small business pursuant to subsection A of this section.

C. In this article, unless the context otherwise requires:

1. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation.

~~2. "Small business" means a business that employed at least two but not more than twenty-five persons at any time during the most recent calendar year and that has been uninsured for at least six months.~~

2. "UNINSURED SMALL BUSINESS" MEANS A SMALL EMPLOYER THAT DID NOT SPONSOR OR PROVIDE A HEALTH BENEFITS PLAN FOR AT LEAST SIX CONSECUTIVE MONTHS IMMEDIATELY BEFORE THE EFFECTIVE DATE OF COVERAGE PROVIDED PURSUANT TO THIS SECTION, EXCEPT THAT THIS REQUIREMENT DOES NOT APPLY AT THE RENEWAL OF COVERAGE PURSUANT TO THIS SECTION.

Sec. 4. Section 36-2901.03, Arizona Revised Statutes, is amended to read:

36-2901.03. Federal poverty program; eligibility

A. The administration shall adopt rules for a streamlined eligibility determination process for any person who applies to be an eligible person as defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The administration shall adopt these rules in accordance with state and federal requirements and the section 1115 waiver.

B. The administration must base eligibility on an adjusted gross income that does not exceed one hundred per cent of the federal poverty guidelines.

C. For persons who the administration determines are eligible pursuant to this section, the date of eligibility is the first day of the month of application.

D. EXCEPT AS PROVIDED IN SUBSECTION E OF THIS SECTION, the administration shall determine an eligible person's continued eligibility on an annual basis.

E. EVERY SIX MONTHS THE ADMINISTRATION SHALL DETERMINE THE CONTINUED ELIGIBILITY OF ANY ADULT WHO IS AT LEAST TWENTY-ONE YEARS OF AGE AND WHO IS SUBJECT TO REDETERMINATION OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES CASH BENEFITS BY THE DEPARTMENT. ACUTE CARE REDETERMINATIONS PURSUANT TO THIS SUBSECTION SHALL BEGIN ON THE EFFECTIVE DATE OF THIS AMENDMENT TO THIS SECTION AND SHALL OCCUR SIMULTANEOUSLY WITH REDETERMINATIONS OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES CASH BENEFITS.

Sec. 5. Section 36-2903.01, Arizona Revised Statutes, is amended to read:

36-2903.01. Additional powers and duties

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider

agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

1. Prescribe uniform forms to be used by all contractors. The rules shall require a written and signed application by the applicant or an applicant's authorized representative, or, if the person is incompetent or incapacitated, a family member or a person acting responsibly for the applicant may obtain a signature or a reasonable facsimile and file the application as prescribed by the administration.

2. Enter into an interagency agreement with the department to establish a streamlined eligibility process to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). At the administration's option, the interagency agreement may allow the administration to determine the eligibility of certain persons including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

3. Enter into an intergovernmental agreement with the department to:

(a) Establish an expedited eligibility and enrollment process for all persons who are hospitalized at the time of application.

(b) Establish performance measures and incentives for the department.

(c) Establish the process for management evaluation reviews that the administration shall perform to evaluate the eligibility determination functions performed by the department.

(d) Establish eligibility quality control reviews by the administration.

(e) Require the department to adopt rules, consistent with the rules adopted by the administration for a hearing process, that applicants or members may use for appeals of eligibility determinations or redeterminations.

(f) Establish the department's responsibility to place sufficient eligibility workers at federally qualified health centers to screen for eligibility and at hospital sites and level one trauma centers to ensure that persons seeking hospital services are screened on a timely basis for eligibility for the system, including a process to ensure that applications for the system can be accepted on a twenty-four hour basis, seven days a week.

(g) Withhold payments based on the allowable sanctions for errors in eligibility determinations or redeterminations or failure to meet performance measures required by the intergovernmental agreement.

(h) Recoup from the department all federal fiscal sanctions that result from the department's inaccurate eligibility determinations. The director may offset all or part of a sanction if the department submits a corrective action plan and a strategy to remedy the error.

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and

services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

5. Apply for and accept federal funds available under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) in support of the system. The application made by the director pursuant to this paragraph shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may be used only for the support of persons defined as eligible pursuant to title XIX of the social security act or the approved section 1115 waiver.

6. At least thirty days before the implementation of a policy or a change to an existing policy relating to reimbursement, provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

C. The director is authorized to apply for any federal funds available for the support of programs to investigate and prosecute violations arising from the administration and operation of the system. Available state funds appropriated for the administration and operation of the system may be used as matching funds to secure federal funds pursuant to this subsection.

D. The director may adopt rules or procedures to do the following:

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or

noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty per cent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to subsection G or H of this section for hospital services or at the rate paid by the health plan, whichever is less.

3. Deputize, in writing, any qualified officer or employee in the administration to perform any act that the director by law is empowered to do or charged with the responsibility of doing, including the authority to issue final administrative decisions pursuant to section 41-1092.08.

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5 and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

E. The director shall adopt rules which further specify the medical care and hospital services which are covered by the system pursuant to section 36-2907.

F. In addition to the rules otherwise specified in this article, the director may adopt necessary rules pursuant to title 41, chapter 6 to carry out this article. Rules adopted by the director pursuant to this subsection shall consider the differences between rural and urban conditions on the delivery of hospitalization and medical care.

G. For inpatient hospital admissions and all outpatient hospital services before March 1, 1993, the administration shall reimburse a hospital's adjusted billed charges according to the following procedures:

1. The director shall adopt rules that, for services rendered from and after September 30, 1985 until October 1, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of holding constant whichever of the following is applicable:

(a) The schedule of rates and charges for a hospital in effect on April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.

(b) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, if the hospital's previous rate schedule became effective before April 30, 1983.

(c) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, limited to five per cent over the hospital's previous rate schedule, and if the hospital's previous rate schedule became effective on or after April 30, 1983 but before October 1, 1983. For the purposes of this paragraph, "constant" means equal to or lower than.

2. The director shall adopt rules that, for services rendered from and after September 30, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of increasing by four per cent a hospital's reimbursement level in effect on October 1, 1985 as prescribed in paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona health care cost containment system administration shall define "adjusted billed charges" as the reimbursement level determined pursuant to this section, increased by two and one-half per cent.

3. In no event shall a hospital's adjusted billed charges exceed the hospital's schedule of rates and charges filed with the department of health services and in effect pursuant to chapter 4, article 3 of this title.

4. For services rendered the administration shall not pay a hospital's adjusted billed charges in excess of the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, eighty-five per cent of the adjusted billed charges.

(b) If the hospital's bill is paid any time after thirty days but within sixty days of the date the bill was received, ninety-five per cent of the adjusted billed charges.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, one hundred per cent of the adjusted billed charges.

5. The director shall define by rule the method of determining when a hospital bill will be considered received and when a hospital's billed charges will be considered paid. Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I shall be considered payment of the hospital bill in full, except that a hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

H. For inpatient hospital admissions and outpatient hospital services on and after March 1, 1993 the administration shall adopt rules for the reimbursement of hospitals according to the following procedures:

1. For inpatient hospital stays, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar

mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety per cent of its 1990 base year costs or more than one hundred ten per cent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half per cent or more than one hundred twelve and one-half per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five per cent or more than one hundred fifteen per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992.

2. For rates effective on October 1, 1994, and annually thereafter, the administration shall adjust tiered per diem payments for inpatient hospital care by the data resources incorporated market basket index for prospective payment system hospitals. For rates effective beginning on October 1, 1999, the administration shall adjust payments to reflect changes in length of stay for the maternity and nursery tiers.

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 per cent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio

that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph on initial receipt of the legible, error-free claim form by the administration if the claim includes the following error-free documentation in legible form:

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I is considered payment by the administration or the contractor of the administration's or contractor's liability for the hospital bill. A hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

5. For services rendered on and after October 1, 1997, the administration shall pay a hospital's rate established according to this section subject to the following:

(a) If the hospital's bill is paid within thirty days of the date the bill was received, the administration shall pay ninety-nine per cent of the rate.

(b) If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the administration shall pay one hundred per cent of the rate.

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of a month following the sixtieth day of receipt of the bill until the date of payment.

6. In developing the reimbursement methodology, if a review of the reports filed by a hospital pursuant to section 36-125.04 indicates that further investigation is considered necessary to verify the accuracy of the information in the reports, the administration may examine the hospital's records and accounts related to the reporting requirements of section

36-125.04. The administration shall bear the cost incurred in connection with this examination unless the administration finds that the records examined are significantly deficient or incorrect, in which case the administration may charge the cost of the investigation to the hospital examined.

7. Except for privileged medical information, the administration shall make available for public inspection the cost and charge data and the calculations used by the administration to determine payments under the tiered per diem system, provided that individual hospitals are not identified by name. The administration shall make the data and calculations available for public inspection during regular business hours and shall provide copies of the data and calculations to individuals requesting such copies within thirty days of receipt of a written request. The administration may charge a reasonable fee for the provision of the data or information.

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty per cent of the hospital specific capital cost and sixty per cent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. The administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index

published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

(b) Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

(i) For the direct costs to support the expansion of graduate medical education programs established before July 1, 2006 at hospitals that do not receive payments pursuant to subdivision (a) of this paragraph. These programs must be approved by the administration.

(ii) For the direct costs to support the expansion of graduate medical education programs established on or before October 1, 1999. These programs must be approved by the administration.

(iii) For the direct costs of graduate medical education programs established on or after July 1, 2006. These programs must be approved by the administration.

(c) The administration shall develop, by rule, the formula by which the monies are distributed.

(d) Each graduate medical education program that receives funding pursuant to subdivision (b) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(e) For the purposes of this paragraph, "graduate medical education program" means a program, including an approved fellowship, that prepares a physician for the independent practice of medicine by providing didactic and clinical education in a medical discipline to a medical student who has completed a recognized undergraduate medical education program.

10. The prospective tiered per diem payment methodology for inpatient hospital services ~~may~~ SHALL include a mechanism for the payment of claims with extraordinary operating costs per day. For tiered per diem rates effective beginning on October 1, 1999, outlier cost thresholds are frozen at the levels in effect on January 1, 1999 and adjusted annually by the administration by the ~~data resources incorporated~~ GLOBAL INSIGHT HOSPITAL market basket index for prospective payment system hospitals. BEGINNING WITH DATES OF SERVICE ON OR AFTER OCTOBER 1, 2007, THE ADMINISTRATION SHALL PHASE IN THE USE OF THE MOST RECENT HOSPITAL SPECIFIC MEDICARE COST-TO-CHARGE RATIOS OR CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVED HOSPITAL SPECIFIC COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING COSTS. THE ADMINISTRATION SHALL COMPLETE FULL IMPLEMENTATION OF THE PHASE-IN ON OR BEFORE OCTOBER 1, 2009. COST-TO-CHARGE RATIOS SHALL BE UPDATED ANNUALLY. ROUTINE MATERNITY CHARGES ARE NOT ELIGIBLE FOR OUTLIER

REIMBURSEMENT. IF A HOSPITAL DOES NOT HAVE A HOSPITAL SPECIFIC MEDICARE COST-TO-CHARGE RATIO, THE ADMINISTRATION SHALL USE THE MOST RECENT STATEWIDE URBAN OR STATEWIDE RURAL AVERAGE MEDICARE COST-TO-CHARGE RATIO.

11. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments.

I. The director may adopt rules that specify enrollment procedures including notice to contractors of enrollment. The rules may provide for varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

J. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

K. The director shall establish a special unit within the administration for the purpose of monitoring the third party payment collections required by contractors and noncontracting providers pursuant to section 36-2903, subsection B, paragraph 10 and subsection F and section 36-2915, subsection E. The director shall determine by rule:

1. The type of third party payments to be monitored pursuant to this subsection.

2. The percentage of third party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred per cent of all third party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

L. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially

responsible relative or representative a claim that exceeds the amount that is reimbursed or should be reimbursed by the system:

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

2. If the claim was paid or should have been paid by the system and the disputed claim has been referred for collection to a collection agency or referred to a credit reporting bureau, the provider that has a contract with a contractor or noncontracting provider shall:

(a) Notify the collection agency and request that all attempts to collect this specific charge be terminated immediately.

(b) Advise all credit reporting bureaus that the reported delinquency was in error and request that the affected credit report be corrected to remove any notation about this specific delinquency.

(c) Notify the administration and the member that the request for payment was in error and that the collection agency and credit reporting bureaus have been notified.

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

M. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid.

N. The director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

O. The administration may contract with contractors for obstetrical care who are eligible to provide services under title XIX of the social security act.

P. Notwithstanding any law to the contrary, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

Q. Notwithstanding any law to the contrary, the administration may receive confidential adoption information to determine whether an adopted child should be terminated from the system.

R. The adoption agency or the adoption attorney shall notify the administration within thirty days after an eligible person receiving services has placed that person's child for adoption.

S. If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection H of this section requiring documentation different than prescribed under subsection H, paragraph 4 of this section.

Sec. 6. Section 36-2912.01, Arizona Revised Statutes, is amended to read:

36-2912.01. Healthcare group fund; nonlapsing

A. The healthcare group fund is established consisting of:

1. Premiums paid by small employers and eligible employees, including employee contributions, for the cost of providing hospitalization and medical care under the system.

2. Gifts, grants and donations.

3. Legislative appropriations.

B. The administration shall administer the fund.

C. Monies in the fund are continuously appropriated and are exempt from the provisions of section 35-190 relating to the lapsing of appropriations. Administrative costs to operate the program are subject to legislative appropriation.

D. On notice from the administration, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund.

E. The administration shall use fund monies to pay the administrative costs and the cost of providing hospitalization and medical care for small employers and eligible employees as defined in section 36-2912.

F. Subject to legislative appropriation, the administration may use fund monies from premiums to pay the administrative costs for the administration to operate the healthcare group program. FOR THE PURPOSES OF THIS SUBSECTION, "administrative costs":

1. INCLUDES ALL COSTS TO SUPPORT AND SUPERVISE THE WORK DONE BY PRIVATE HEALTH PLANS.

2. Do not include commissions or fees paid by the healthcare program to insurance producers.

Sec. 7. Section 36-2930, Arizona Revised Statutes, is amended to read:

36-2930. Temporary medical coverage program; qualifications; fund; program termination

A. The temporary medical coverage program is established. Beginning October 1, 2006, the administration shall establish eligibility for the program for any uninsured person who meets the following requirements:

1. Is a resident of this state.

2. Is a citizen of the United States or a legal resident that meets the requirements of section 36-2903, subsection B or C.

3. Submits an application as prescribed by the administration.

4. Has been eligible for services pursuant to section 36-2901, paragraph 6 or section 36-2931, paragraph 5 and enrolled in the system, excluding persons who are receiving services pursuant to section 36-2912, at any time within twenty-four months before the person submits an application pursuant to paragraph 3 of this subsection.

5. Is receiving benefits pursuant to 42 United States Code section 423.

6. Is not eligible for medicare benefits pursuant to 42 United States Code section 426(b) or section 426-1.

B. The director may adopt rules to implement the program and the requirements of this section and to prescribe the following:

1. The application process.

2. Actuarially sound capitation rates.

3. The collection of monthly premiums from program enrollees. Monthly premiums shall not exceed the capitation rate paid to health plans for the enrollee and shall be based on the enrollee's gross household income with tiered premiums for any enrollee whose income is:

(a) More than one hundred but not more than one hundred fifty per cent of the federal poverty guidelines.

(b) More than one hundred fifty but not more than two hundred per cent of the federal poverty guidelines.

(c) More than two hundred but not more than two hundred fifty per cent of the federal poverty guidelines.

(d) More than two hundred fifty but not more than three hundred per cent of the federal poverty guidelines.

(e) More than three hundred per cent of the federal poverty guidelines.

C. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906.

D. Unless otherwise required by the administration, the health plans shall provide medically necessary health and medical services as required by section 36-2907.

E. A person who is enrolled in the program must notify the administration when the person becomes eligible for medicare benefits through 42 United States Code section 426(b) or section 426-1. A person who is enrolled in the program and who becomes eligible for medicare benefits is ineligible for the program.

F. If the director determines that monies may be insufficient for the program, the administration may stop processing applications until the administration is able to verify that funding is sufficient to fund the program.

G. The temporary medical coverage fund is established consisting of premiums collected from enrollees pursuant to subsection B of this section, ~~legislative appropriations,~~ gifts, grants and donations received by the administration to operate the program. The administration shall use fund monies to pay for the services and costs associated with persons who are eligible pursuant to this section. On notice from the administration, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are subject to legislative appropriation.

H. The program established by this section ends on July 1, 2016 pursuant to section 41-3102.

Sec. 8. Section 36-3410, Arizona Revised Statutes, is amended to read:

36-3410. Regional behavioral health authorities; contracts; monthly summaries; inspection; copying fee; children's behavioral health services; transfers; prohibition

A. If the department contracts with behavioral health contractors which would act as regional behavioral health authorities or directly with a service provider for behavioral health services, the department and each behavioral health contractor or service provider shall prepare and make available monthly summary statements, in a format prescribed by the department, that separately detail by title XIX and nontitle XIX and by service category and service type, as defined by contract with the department, the number of clients served, the units of service provided and the state and federal monies distributed through the department to each regional behavioral health authority or direct contract service provider and the amounts distributed by each regional behavioral health authority or direct contract service provider to their subcontractors. The director may require additional information in the monthly statement which the director determines to be critical for proper regulation and oversight of the regional behavioral health authority or the direct contract service provider.

B. FOR SERVICES PROVIDED DIRECTLY BY A REGIONAL BEHAVIORAL HEALTH AUTHORITY, THE MAXIMUM REIMBURSEMENT TO THAT REGIONAL BEHAVIORAL HEALTH AUTHORITY SHALL BE THIRTY PER CENT ABOVE THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM FEE FOR SERVICE RATE FOR THE PARTICULAR SERVICE RENDERED.

C. BEHAVIORAL HEALTH CONTRACTORS UNDER CONTRACT WITH THE DEPARTMENT TO ACT AS REGIONAL BEHAVIORAL HEALTH AUTHORITIES MAY PERFORM ONLY MANAGED CARE FUNCTIONS. REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES SHALL NOT DELIVER BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS. THE PROHIBITION ON REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES DELIVERING BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS SHALL BE FULLY IMPLEMENTED BY SEPTEMBER 1, 2009.

~~B.~~ D. In the contracts specified under subsection A of this section, the department may include a provision to charge for services provided at the state hospital. The charges are only for clients on whose behalf the contractor has been paid by the department.

~~C.~~ E. The summaries and the contracts on which they are based are open to public inspection. The department and each regional behavioral health authority or direct contract service provider shall make the summaries available for inspection and copying at the office of each regional behavioral health authority or direct contract service provider and at the department.

~~D.~~ F. The department and a regional behavioral health authority or direct contract service provider shall charge a copying fee which is not in excess of the actual cost of reproduction or the amount charged by the secretary of state pursuant to section 41-126, whichever is less.

~~E.~~ G. Copying fees received by the department, pursuant to subsection ~~D~~ F of this section, shall be placed in the state general fund.

~~F.~~ H. Monies appropriated for fiscal year 2001-2002 and each fiscal year thereafter for children's behavioral health services shall be spent on services only as prescribed by the appropriation and may not be used for any other purpose.

I. MONIES APPROPRIATED FOR FISCAL YEAR 2007-2008 AND EACH FISCAL YEAR THEREAFTER FOR SERIOUSLY MENTALLY ILL SERVICES SHALL BE SPENT ON SERVICES ONLY AS PRESCRIBED BY THE APPROPRIATION AND MAY NOT BE USED FOR ANY OTHER PURPOSE.

Sec. 9. Section 38-654, Arizona Revised Statutes, is amended to read:

38-654. Special employee health insurance trust fund; purpose; investment of monies; use of monies; exemption from lapsing; annual report

A. There is established a special employee health insurance trust fund for the purpose of administering the state employee health insurance benefit plans. The fund shall consist of legislative appropriations, monies collected from the employer and employees for the health insurance benefit plans and investment earnings on monies collected from employees. The fund shall be administered by the director of the department of administration. Monies in the fund that are determined by the legislature to be for administrative expenses of the department of administration, including monies authorized by subsection D, paragraph 4 of this section, are subject to legislative appropriation.

B. On notice from the department of administration, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. There shall be a separate accounting of monies contributed by the employer, monies collected from state employees and investment earnings on monies collected from employees. Monies collected from state employees for health insurance benefit plans shall be expended prior to expenditure of monies contributed by the employer.

C. The director of the department of administration may authorize the employer health insurance contributions by fund to be payable in advance whether the budget unit is funded in whole or in part by state monies. By July 15 each year, the joint legislative budget committee staff shall determine the amount appropriated for employer health insurance contributions. The department of administration may transfer to the special employee health insurance trust fund in whole or in part the amount appropriated to budget units for employer health insurance contributions as deemed necessary.

D. Monies in the fund shall be used by the department of administration for the following purposes for the benefit of officers and employees who participate in a health insurance benefit plan pursuant to this article:

1. To administer a health insurance benefit program for state officers and employees.

2. To pay health insurance premiums, claims costs and related administrative expenses.

3. To apply against future premiums, claims costs and related administrative expenses.

4. To apply the equivalent of not more than one dollar fifty cents for each employee for each month to administer applicable federal and state laws relating to health insurance benefit programs and to design, implement and administer improvements to the employee health insurance or benefit program.

E. Subsection D of this section shall not be construed to require that all monies in the special employee health insurance trust fund shall be used within any one or more fiscal years. Any person who is no longer a state employee or an employee who is no longer a participant in a health insurance plan under contract with the department of administration shall have no claim upon monies in the fund.

F. Monies deposited in or credited to the fund are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

G. Claims for services rendered prior to July 1, 1989 shall not be paid from the special employee health insurance trust fund.

H. The department of administration shall submit an annual report on the financial status of the special employee insurance trust fund to the governor, the president of the senate, the speaker of the house of representatives, the chairpersons of the house and senate appropriations committees and the joint legislative budget committee staff by March 1 ~~of each year~~. The report shall include:

1. The actuarial assumptions and a description of the methodology used to set premiums and reserve balance targets for the health insurance benefit program for the current plan year.

2. An analysis of the actuarial soundness of the health insurance benefit program for the previous plan year.

3. An analysis of the actuarial soundness of the health insurance benefit program for the current plan year, based on both year-to-date experience and total expected experience.

4. A preliminary estimate of the premiums and reserve balance targets for the next plan year, including the actuarial assumptions and a description of the methodology used.

5. ANY CHANGE TO THE TYPE OF BENEFITS OFFERED UNDER THE PLAN IN THE UPCOMING PLAN YEAR.

I. THE DEPARTMENT SHALL SUBMIT A REPORT TO THE JOINT LEGISLATIVE BUDGET COMMITTEE DETAILING ANY CHANGES TO THE TYPE OF BENEFITS OFFERED UNDER THE PLAN AND ASSOCIATED COSTS THAT WERE NOT INCLUDED IN THE ANNUAL REPORT AS REQUIRED BY SUBSECTION H OF THIS SECTION AT LEAST FORTY-FIVE DAYS BEFORE MAKING THE CHANGE. THE REPORT SHALL INCLUDE:

1. AN ESTIMATE OF THE COSTS OR SAVINGS ASSOCIATED WITH THE CHANGE BY EMPLOYEE AND EMPLOYER SHARE OF PREMIUMS, OR LOSS OR GAIN TO THE HEALTH INSURANCE TRUST FUND RESERVE. PREMIUM CHANGES SHALL BE DELINEATED BY GENERAL FUND, OTHER FUND AND EMPLOYEE SHARE.

2. AN EXPLANATION OF WHY THE CHANGE WAS IMPLEMENTED BEFORE THE NEXT PLAN YEAR.

Sec. 10. Section 46-803, Arizona Revised Statutes, is amended to read:

46-803. Eligibility for child care assistance

A. The department shall provide child care assistance to eligible families who are attempting to achieve independence from the cash assistance program and who need child care assistance in support of and as specified in their personal responsibility agreement pursuant to chapters 1 and 2 of this title.

B. The department shall provide child care assistance to eligible families who are transitioning off of cash assistance due to increased earnings or child support income in order to accept or maintain employment. Eligible families must request this assistance within six months after the cash assistance case closure. Child care assistance may be provided for up to twenty-four months after the case closure and shall cease whenever the family income exceeds one hundred sixty-five per cent of the federal poverty level.

C. The department shall provide child care assistance to eligible families who are diverted from cash assistance pursuant to section 46-298 in order to obtain or maintain employment. Child care assistance may be provided for up to twenty-four months after the case closure and shall cease whenever the family income exceeds one hundred sixty-five per cent of the federal poverty level.

D. The department may provide child care assistance to support eligible families with incomes of one hundred sixty-five per cent or less of the federal poverty level to accept or maintain employment. Priority for this child care assistance shall be given to families with incomes of one hundred per cent or less of the federal poverty level.

E. The department may provide child care assistance to families referred by child protective services and to children in foster care pursuant to title 8, chapter 5 to support child protection.

F. The department may provide child care assistance to special circumstance families whose incomes are one hundred sixty-five per cent or less of the federal poverty level and who are unable to provide child care for a portion of a twenty-four hour day due to a crisis situation of domestic violence or homelessness, or a physical, mental, emotional or medical condition, participation in a drug treatment or drug rehabilitation program or court ordered community restitution. Priority for this child care assistance shall be given to families with incomes of one hundred per cent or less of the federal poverty level.

G. In lieu of the employment activity required in subsection B, C or D of this section, the department may allow eligible families with teenaged custodial parents under twenty years of age to complete a high school diploma or its equivalent or engage in remedial education activities reasonably related to employment goals.

H. The department may provide supplemental child care assistance for department approved education and training activities if the eligible parent, legal guardian or caretaker relative is working at least a monthly average of twenty hours per week and this education and training are reasonably related to employment goals. The eligible parent, legal guardian or caretaker relative must demonstrate satisfactory progress in the education or training activity.

I. Beginning March 12, 2003, the department shall establish waiting lists for child care assistance and prioritize child care assistance for different eligibility categories in order to manage within appropriated and available monies. Priority of children on the waiting list shall start with those families at one hundred per cent of the federal poverty level and continue with each successive ten per cent increase in the federal poverty level until the maximum allowable federal poverty level of one hundred sixty-five per cent. Priority shall be given regardless of time spent on the waiting list.

J. The department shall establish criteria for denying, reducing or terminating child care assistance that include:

1. Whether there is a parent, legal guardian or caretaker relative available to care for the child.

2. Financial or programmatic eligibility changes or ineligibility.

3. Failure to cooperate with the requirements of the department to determine or redetermine eligibility.

4. Hours of child care need that fall within the child's compulsory academic school hours.

5. Reasonably accessible and available publicly funded early childhood education programs.

6. Whether an otherwise eligible family has been sanctioned and cash assistance has been terminated pursuant to chapter 2 of this title.

7. Other circumstances of a similar nature.

8. Whether sufficient monies exist for the assistance.

K. Families receiving child care assistance under subsection D or F of this section are also subject to the following requirements for such child care assistance:

1. Each ~~child~~ FAMILY is limited to no more than ~~sixty~~ FORTY-EIGHT cumulative months of child care assistance. The department may provide an extension if the family can prove that the family is making efforts to improve skills and move towards self-sufficiency.

2. Families are limited to no more than six children receiving child care assistance.

3. Copayments shall be imposed for all children receiving child care assistance. Copayments for each child may be higher for the first child in child care than for additional children in child care.

L. The department shall review each case at least once a year to evaluate eligibility for child care assistance.

M. The department shall report on December 31 and June 30 of each year to the joint legislative budget committee the total number of families who applied for child care assistance and the total number of families who were denied assistance under this section because the parents, legal guardians or caretaker relatives who applied for assistance were not citizens or legal residents of the United States or were not otherwise lawfully present in the United States.

N. This section shall be enforced without regard to race, religion, gender, ethnicity or national origin.

O. Notwithstanding section 35-173, monies appropriated for the purposes of this section shall not be used for any other purpose without the approval of the joint legislative budget committee.

P. The department shall refer all child care subsidy recipients to child support enforcement and to local workforce services and provide information on the earned income tax credit.

Sec. 11. AHCCCS; acute care redeterminations; report

The Arizona health care cost containment system administration shall report to the president of the senate, the speaker of the house of representatives and the joint legislative budget committee on or before February 10, 2008 on the effects through January 2008 of changing the redetermination period for the population described in section 36-2901.03, subsection E, Arizona Revised Statutes, as amended by this act. The report shall include the number of redetermination letters sent out, the number of redetermination interviews conducted and the number of redetermination interviews resulting in continued acute care benefits.

Sec. 12. County acute care contribution; fiscal year 2007-2008

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2007-2008 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

| | | |
|---|---|---|
| 1. | Apache | $ 268,800 |
| 2. | Cochise | $ 2,214,800 |
| 3. | Coconino | $ 742,900 |
| 4. | Gila | $ 1,413,200 |
| 5. | Graham | $ 536,200 |
| 6. | Greenlee | $ 190,700 |
| 7. | La Paz | $ 212,100 |
| 8. | Maricopa | $23,067,900 |
| 9. | Mohave | $ 1,237,700 |
| 10. | Navajo | $ 310,800 |
| 11. | Pima | $14,951,800 |

| | | |
|---|---|---|
| 12. | Pinal | $ 2,715,600 |
| 13. | Santa Cruz | $ 482,800 |
| 14. | Yavapai | $ 1,427,800 |
| 15. | Yuma | $ 1,325,100 |

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system and long-term care system funds established by section 36-2913, Arizona Revised Statutes, from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirements as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer shall not withhold distributions from the highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the amounts paid pursuant to subsection C of this section and amounts withheld pursuant to subsection B of this section in the Arizona health care cost containment system and long-term care system funds established by section 36-2913, Arizona Revised Statutes.

E. If payments made pursuant to subsection C of this section exceed the amount required to meet the costs incurred by the Arizona health care cost containment system for the hospitalization and medical care of those persons defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the Arizona health care cost containment system administration may instruct the state treasurer either to reduce remaining payments to be paid pursuant to this section by a specified amount or to provide to the counties specified amounts from the Arizona health care cost containment system and long-term care system funds.

F. It is the intent of the legislature that the Maricopa county contribution pursuant to subsection A of this section be reduced in each subsequent year according to the changes in the GDP price deflator. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563, Arizona Revised Statutes.

Sec. 13. ALTCS; county contributions

Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2007-2008 are as follows:

| | | |
|---|---|---|
| 1. | Apache | $ 584,100 |
| 2. | Cochise | $ 5,350,300 |
| 3. | Coconino | $ 1,752,600 |
| 4. | Gila | $ 2,248,600 |
| 5. | Graham | $ 1,042,800 |
| 6. | Greenlee | $ 129,100 |
| 7. | La Paz | $ 841,400 |
| 8. | Maricopa | $150,143,900 |
| 9. | Mohave | $ 7,851,100 |
| 10. | Navajo | $ 2,416,200 |
| 11. | Pima | $ 38,846,800 |
| 12. | Pinal | $ 10,781,400 |
| 13. | Santa Cruz | $ 1,791,100 |
| 14. | Yavapai | $ 8,443,500 |
| 15. | Yuma | $ 6,340,300 |

Sec. 14. Withholding state shared revenues; fiscal year 2007-2008

A. Based on the distribution of disproportionate share funding to county operated hospitals made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, as amended by this act, for fiscal year 2007-2008 the director of the joint legislative budget committee shall compute amounts to be withheld from transaction privilege tax revenues for counties with a population of at least one million five hundred thousand persons pursuant to subsection B of this section.

B. Notwithstanding section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, beginning with the first monthly distribution of transaction privilege tax revenues and at the direction of the governor, the state treasurer shall withhold an amount totaling $84,652,400 from state transaction privilege tax revenues otherwise distributable, after any amounts withheld for the county long-term care contribution for fiscal year 2007-2008 from counties with a population of at least one million five hundred thousand persons. Amounts withheld from individual counties under this subsection shall be determined pursuant to subsection A of this section.

C. In addition to the amount specified in subsection B of this section, the state treasurer may also withhold transaction privilege tax revenues in fiscal year 2008-2009 if amounts withheld pursuant to subsection B of this section for fiscal year 2007-2008 are insufficient.

D. If changes in federal policies regarding the disproportionate share funding to county operated hospitals reduce payment levels below the amount specified in the fiscal year 2007-2008 general appropriations act, the governor, after consultation with chairpersons of the house and senate

appropriations committees, may direct the state treasurer to suspend withholdings of transaction privilege tax revenues specified in subsection B of this section to accommodate the federal policy change.

Sec. 15. Hospitalization and medical care contribution; fiscal year 2006-2007

A. Notwithstanding any other law, for fiscal year 2007-2008, beginning with the second monthly distribution of transaction privilege tax revenues, the state treasurer shall withhold the following amounts from state transaction privilege tax revenues otherwise distributable, after any amounts withheld for the county long-term care contribution or the county administration contribution pursuant to section 11-292, subsection P, Arizona Revised Statutes, for deposit in the Arizona health care cost containment system fund established by section 36-2913, Arizona Revised Statutes, for the provision of hospitalization and medical care:

| | | |
|---|---|---|
| 1. | Apache | $ 87,300 |
| 2. | Cochise | $ 162,700 |
| 3. | Coconino | $ 160,500 |
| 4. | Gila | $ 65,900 |
| 5. | Graham | $ 46,800 |
| 6. | Greenlee | $ 12,000 |
| 7. | La Paz | $ 24,900 |
| 8. | Mohave | $ 187,400 |
| 9. | Navajo | $ 122,800 |
| 10. | Pima | $1,115,900 |
| 11. | Pinal | $ 218,300 |
| 12. | Santa Cruz | $ 51,600 |
| 13. | Yavapai | $ 206,200 |
| 14. | Yuma | $ 183,900 |

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirement as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer shall not withhold distributions from the highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total monies prescribed pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from

the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the monies paid pursuant to subsection C of this section in the Arizona health care cost containment system fund established by section 36-2913, Arizona Revised Statutes.

E. In fiscal year 2007-2008, the sum of $2,646,200 withheld pursuant to subsection A or B of this section, as applicable, is allocated for the county acute care contribution for the provision of hospitalization and medical care services administered by the Arizona health care cost containment system administration.

Sec. 16. Child care eligibility levels; report

Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal year 2007-2008, the department of economic security may reduce maximum income eligibility levels for child care assistance in order to manage within appropriated and available monies. The department shall notify the joint legislative budget committee of any change in maximum income eligibility levels for child care within fifteen days after implementing that change.

Sec. 17. Competency restoration treatment; county and city reimbursement; fiscal year 2007-2008; deposit; tax withholding

A. Notwithstanding section 13-4512, Arizona Revised Statutes, if the state pays the costs of a defendant's inpatient competency restoration treatment pursuant to section 13-4512, Arizona Revised Statutes, for counties with a population of eight hundred thousand or more persons and for all cities, the city or county shall reimburse the department of health services for eighty-six per cent of these costs for fiscal year 2007-2008.

B. The department shall deposit the reimbursements, pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state hospital fund established by section 36-545.08, Arizona Revised Statutes.

C. Each city and county shall make the reimbursements for these costs as specified in subsection A of this section within thirty days after a request by the department. If the city or county does not make the reimbursement, the superintendent of the Arizona state hospital shall notify the state treasurer of the amount owed and the treasurer shall withhold the amount, including any additional interest as provided in section 42-1123, Arizona Revised Statutes, from any transaction privilege tax distributions to the city or county. The treasurer shall deposit the withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state hospital fund established by section 36-545.08, Arizona Revised Statutes.

Sec. 18. Health insurance premiums; department of administration

For fiscal year 2007-2008, the department of administration shall not implement a differentiated health insurance premium based on the integrated or nonintegrated status of a health insurance provider available through the state employee health insurance program beginning October 1, 2007.

Sec. 19. Children's health insurance program; parents eligibility; fiscal year 2007-2008

A. Notwithstanding any other law, for fiscal year 2007-2008, a parent of a child who is eligible for or enrolled in the children's health insurance program or a parent who has a child enrolled under title 36, chapter 29, article 1, Arizona Revised Statutes, but who would be eligible for the children's health insurance program, is eligible for the children's health insurance program prescribed in title 36, chapter 29, article 4, Arizona Revised Statutes, and may apply for eligibility based on an income that does not exceed two hundred per cent of the federal poverty level.

B. Eligibility and program continuation is dependent on the continuation of an enhanced federal matching rate for state monies. The program ends on expiration of the enhanced federal matching rate.

C. In determining eligibility pursuant to subsection A of this section, the administration shall apply other eligibility requirements pursuant to sections 36-2981 and 36-2983, Arizona Revised Statutes, and rules adopted by the administration. If the parent is determined eligible pursuant to this section, except as provided in subsection D of this section, all other requirements established by the administration by rule, including available services, pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, apply.

D. Persons receiving services under this section shall make premium payments on a monthly basis. The director of the Arizona health care cost containment system administration shall adopt rules to prescribe tiered premiums based on the following:

1. For households with incomes of more than one hundred per cent but less than one hundred fifty per cent of the federal poverty guidelines, the premium is equal to three per cent of the household's net income.

2. For households with incomes of at least one hundred fifty per cent but less than one hundred seventy-five per cent of the federal poverty guidelines, the premium is equal to four per cent of the household's net income.

3. For households with incomes of at least one hundred seventy-five per cent but not more than two hundred per cent of the federal poverty guidelines, the premium is equal to five per cent of the household's net income.

E. Premiums paid pursuant to subsection D of this section apply to the entire household unit, regardless of the number of parents or children participating.

Sec. 20. AHCCCS; exclusions from outlier payment report

The Arizona health care cost containment system administration shall work with impacted stakeholders, including hospitals and health plans, to evaluate whether certain types of procedures or services, including implants, medications and operating room charges, should be excluded from outlier payments or paid under a different methodology and shall report its findings

to the joint legislative budget committee on or before December 31, 2007. The report shall include a fiscal impact analysis and a review of statutory changes required to implement the recommendations.

Sec. 21. AHCCCS; exemption from rule making

The Arizona health care cost containment system administration is exempt from rule making requirements of title 41, chapter 6, Arizona Revised Statutes, until October 1, 2008 in order to implement a revised outlier reimbursement methodology pursuant to this act.

Sec. 22. AHCCCS; nonemergency transportation report

The Arizona health care cost containment system administration shall report to the joint legislative budget committee on or before December 15, 2007 on nonemergency transportation usage. The report shall include, at a minimum, the estimated costs of emergency and nonemergency transportation and potential cost-saving modifications to nonemergency transportation utilization.

Sec. 23. Health savings account pilot program; review

A. The department of administration shall design a pilot program for the use of health savings accounts with a qualifying state-sponsored high deductible health plan, as defined in Public Law 108-173, for state employees. On or before December 1, 2007, the department shall submit the pilot program design to the joint legislative budget committee for review. The program design report may include multiple options for final implementation, which may include various levels of state participation or benefit design. For each option, the pilot program design shall include:

1. A high deductible health plan offered by each vendor that offers a health plan through the state employee health insurance program.
2. Benefit design, including deductible amounts, for the qualifying high deductible health plan.
3. Premium amounts for the qualifying high deductible health plan.
4. Employee and employer contribution strategy for the high deductible health plan premiums.
5. Employer and employee contribution strategy for health savings account deposits.
6. The ability for employees to make pre-tax contributions to the health savings accounts through a salary reduction arrangement.
7. Options for custodial or trustee arrangement of the health savings account.
8. Investment options for account holders.
9. Administrative costs.
10. Actuarial assumptions, including demographic, participation and utilization assumptions, used in program design.
11. Impact analysis of offering the high deductible option on existing health plans.

B. The department of administration shall not implement the pilot program until after the joint legislative budget committee review of the program design pursuant to subsection A.

C. The average per person employer cost of the pilot program, including the contributions for the health savings account and the high deductible health plan, shall not exceed the average per person employer cost of the self-insured state employee health benefits program for the same fiscal year.

D. On or before November 1, 2008, and each year thereafter, the department shall submit a report to the joint legislative budget committee detailing the enrollment and expenditures for the pilot program in total and by plan option.

E. This pilot program shall be operated through September 30, 2012.

Sec. 24. Delayed repeal

Section 23 of this act, relating to the health savings account pilot program, is repealed from and after September 30, 2012.

Sec. 25. AHCCCS; risk pool report

The Arizona health care cost containment system administration shall report to the joint legislative budget committee on or before December 1, 2007 on the feasibility of establishing a risk pool for the uninsured and high risk populations. The report shall include, at a minimum, the estimated eligible population, membership, premiums, benefit package and estimated state contribution.

Sec. 26. Appropriations; regenerative tissue repository; exemption

A. The sum of $3,000,000 is appropriated from the state general fund in each of the fiscal years 2007-2008, 2008-2009, 2009-2010, 2010-2011 and 2011-2012 to the department of health services for centralized Arizona repositories of diverse types of human stem cells of nonembryonic origin obtained in this state. The department shall establish a competitive request for proposal process to establish the repositories.

B. The appropriations made in subsection A of this section are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Sec. 27. Retroactivity

Section 20-2341, Arizona Revised Statutes, as amended by this act, applies retroactively to September 21, 2006.